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FINAL REPORT
of the
NARCOTIC PROJECT

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THE FINAL REPORT ON THE NARCOTIC UNIT PHILADELPHIA, PENNSYLVANIA

By

Paul J. Gernert
Chairman

Since 1960, the then Board of Parole, (changed to Board of Probation and Parole July 1, 1968), has had a narcotic unit, consisting of five (5) specially-trained agents, one (1) supervisor and a Clinical Psychologist. This unit functioned only in the Philadelphia area. There are two (2) valid reasons for locating the unit there. First, that is where the majority of drug users, and on parole, were located; second, the area adapted itself to innovations with cooperation from law enforcement, the Courts, the hospitals, and the community.

When the unit was first established, we had coordinated two (2) existing programs that related to our services. One was in New York under direct control of the New York Parole Authority and the other in California. In our evaluation of the two (2) programs in their first year of operation, we found that the New York Program, in most part, best fitted our needs.

Our records indicate that the most addicted persons are frequently free of any arrests for the misuse of narcotics, therefore, are not under sentence for violating the narcotic laws.

They are generally convicted of larcency, (shoplifting), burglary and a few, in more violent crimes, to obtain funds to support their habits.

The Board Members, in their parole interviews, are able to refer many such addicted persons when paroled to our treatment unit.

A survey of cases, with addition histories, indicated that only sixty percent (60%) were sentenced for violation of the narcotic statutes. The other forty percent (40%) were for other criminal violations. In one specific case, the inmate was using heroin, in quantity up to Fifty Dollars ($50.00) daily and his funds came from pandering. Yet, he never had an arrest or conviction for narcotic violations.

Another, with a Twenty Dollar ($20.00) daily habit and on heroin for ten (10) years, supported his habit through burglarizing delivery trucks of merchandise valued in the thousands.

One problem that has prevented futher expansion of the unit, is personnel.

The personnel who were assigned to this unit were, to the man, deeply interested and willing to train themselves with the needed skills for effective program.

However, one area was the highly trained professional. We began with a full-time Clinical Psychologist, but had to settle in the recent year with a part-time Psychologist.

The unit has fully demonstrated to the Board that compulsive behavior (drug addicted persons fall under this label), can be converted to productivity. We believe other types of compulsive behavior can be equally aided, once we have sufficient staff to expand the unit.

The following is the final report, prepared by our part-time Psychologist, Albert Levitt, who, until a year ago, was the full-time Clinical Director of the unit.

PHASE II

In July 1962, Phase II of the experimental narcotic unit was established to further intensify the study of the differences between therapy and non-therapy groups of addicts. After forty-two (42) months the study revealed the following statistics of 214 randomly selected addicts:

Table III

	109 Addicts In Therapy	105 Addicts Non-Therapy	Difference
Parole Drug Failure Rate	12.8%*	14%	- 1.2%
Total Failure Rate	29.3%	30.5%	- 1.2%
Received Final Discharge	23.9%	27.6%	- 4.3%
Active and Final Discharge	74.9%	71.4%	+ 3.5%
Failure after Parole*	26.9%	27.2%	- 3%
Drug Failure Rate After Parole	19.2%	20.7%	- 1.5%
Total Drug Failure Rate on & Off Parole	18.3%	20%	- 1.7%

*Figures Rounded.

Actually, the therapy groups were more closely supervised since they had to report in person once a week for therapy. Any absence was immediately followed up with a home visit by the parole agent to determine the cause of the absence. Most group therapy was held at night to make attendance convenient after working hours, and one morning group session was conducted for men working nights.

Table III reveals no significant difference between the two groups, although there is a very slight tendency for those addicts in therapy to succeed at a higher rate. These figures should not be interpreted to mean therapy is not effective, but rather it does indicate that close supervision of addicts is an effective deterrent to their recidivism.

Moreover, the figures are somewhat misleading. Many addicts who failed on parole in Phase I returned to prison and were released to Phase II. This means Phase II was receiving the more difficult addicts to cure and those with more severe personality problems and who were less amenable to the treatment methods employed by the Board of Parole. Approximately 33 addicts who failed in Phase I found their way into Phase II.

The figures for success* in Phase II are encouragingly high for both groups over a 42-month period of time. Moreover, the figures remain high even with an attrition failure rate of 8 to 10% every subsequent year until the figure for success stabilizes at about 50% for a six-year period. This report should dispel the commonplace idea that addicts are incurable, and should lend credence to the idea that addicts need close control until they can function adequately on their own. In this regard, the irregular but frequent gas chromatographical method of urinalysis employed with addicts played a significant part in reducing a return to illegal drug use.

Parole agent personality also played a significant role in the success and failure rates. Although given extensive training, the individual

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*Success based on no arrest for a new crime nor returned to prison for parole violations.

philosophy and supervisory methods of the agents differed widely. One agent, while very strict and who made frequent physical checks on living arrangements and job status, avoided taking urine samples. If an addict in his caseload reverted to drug use, he invariably took this act as a personal slight and recommended long term return to institutional life. Another agent was extremely overprotective of his parolees, and while he utilized urinalysis, he would avoid short term return to prison and invariably lost many cases, since they were usually arrested for other crimes or new drug offenses. Both agents never really understood the learning process of the maze program. Another agent attempted a close, friendly relationship with his parolees, which they neither understood nor trusted, and they privately complained that they could not talk to him, or they felt he became too close emotionally to their personal lives. He had the highest failure rate. He attempted to be supportive and never really understood the negativism of the parolees or the learning method of the program. All the agents resisted placing a parolee away for 48 hours if therapy was missed, because the county prison was too far away to make such a procedure convenient; and all the agents believed that very short term incarceration would not have worthwhile therapeutic effects.

The problem of bridging the gap between philosophies of the professional psychologist and parole agent at times seemed insurmountable. The need to maintain standard procedures and objectivity for research ran headlong into parole agent emotionalism when it threatened their working relationship with the parolee. Frequently, the psychopathic nature and intuitiveness of the parolee was capable of having the authorities fighting over him, while he escaped direction, unscathed. While these internal

problems existed, and to the extent that they were resolved had an effect on the on the success of the narcotic program. It is reported in this paper not as a criticism of either side (professional or parole agent), but as a facet of the program so that it may be of help to others in understanding what hidden factors affect the nature of this type of program. Matching the personality type of the parole agent and parolee needs extensive research before it can be attempted, but this writer holds to the opinion that personality interactions should be held to a minimum with addicts and cold, objective learning theory methods will have better, long-term results. This does not mean the parole agent cannot be friendly, but it means the parole agent must accept a dependent variable status and function in an automatic manner when the addict attempts to escape the treatment maze. Otherwise, the addicts, who are expert at ingratiating themselves to avoid working or avoid functioning independently, succeed in maintaining their self-defeating, dependent life style.

On separate occasions some parole agents made it mandatory for parolees in group 2 (a non-therapy group) to attend therapy. When the mistake was realized, they were continued in treatment. This accounts for the discrepancy between 109 treated addicts and 105 non-treated addicts in Phase II. Otherwise, the random selection of addicts for therapy or non-therapy groups was conducted with accuracy.

PHASE III

By October 1963, Dr. Kurt O. Konietzko had decided to initiate an institutional group therapy program to provide ongoing treatment for recidivists and for inmates who eventually would come into the narcotic unit. The institutional move toward treatment provided the Philadelphia Narcotic Unit with a complete treatment cycle not found with any other treatment program in the United States. Though all addict personalities do not respond to a group therapy approach, it was the only practical approach to the problem, in view of the limited treatment personnel.

Groups were established at Philadelphia County Prison (Holmesburg) with the kind permission of Superintendent Edward J. Hendrick whose cooperation deserves special commendation.

Four groups were started and treatment took place once a week (Tuesday). Many addicts in the prison voluntarily joined the groups hoping to receive special consideration for early parole or other unknown special favors. Few seemed genuinely interested in self-improvement. To some, it was only some relief from the institutional routine.

Institutional treatment in these groups consisted of providing a no holds barred, direct confrontation approach between the therapist and addicts, and then between the addicts themselves. No rules were allowed during the therapy session except for rules agreed upon by the group itself unanimously. The only rule enforced was that no one could resort to physical acting out in therapy. To date, no violence has occurred in any of the groups, and the program has presented no management problems to the institution. Anyone from the Warden down was allowed in to observe and

participate. Therapy was usually conducted by co-therapists who would support and reinforce each other at all times so as not to allow the psychopathic device of playing one therapist against the other to occur. Realizing most inmates are initially hostile to authority this problem was dealt with first and an attempt was made to desensitize it. Realizing also that sociopaths do not readily learn under non-stressful conditions but learn rapidly when anxious, anxiety producing manipulations were continually invoke. Within the institution anxiety was easier to evoke and most of the inmates respond very favorably to this approach and tend to prefer it. Some addicts, usually those who are extremely unstable or thoroughly committed to a dysocial life would not respond and would not attend the program. In all who were exposed to this approach, not more than ten rejected it completely. At the time statistics were gathered for this report 33 cases had matriculated out of institution but approximately 150 addicts were in treatment at this institution.

In 1965, another group therapy program was started at the State Correctional Institution at Philadelphia with the permission of former Superintendent Rundle. The same approach was initiated with similar results. No management problems arose at either institution, and at present, groups are conducted twice a week at this institution, and as of this writing, plans are under-way to start therapy groups at Graterford.

The results of institutional therapy upon the parolee are extremely interesting. Although 33 cases are reported upon in this report, during the time lapse many more addicts have been released and followed on parole, giving this writer more hindsight in commenting upon the results.

In general, addicts exposed to institutional therapy respond much better to parole supervision than inmates not exposed to treatment. It is estimated that it takes approximately one year to break through the passive agressive defenses of addicts not initially exposed to institutional treatment. Institutional treatment from this standpoint alone is valuable. The parole agents report parolees who have had institutional therapy are more flexible, cooperative and by and large rapidly establish more appropriate rapport with parole programs. With parolees who have had no institutional therapy, treatment in the community setting must be toned down considerably, and anxiety producing situations must be minimized because they may not show their anger to the therapy situation, but they may act it out against the community.

The results for the first eight months with these 33 cases appears phenomenally high and sucessful--87.9% success. The failure rate picks up after this period and results tend to stabilize again about the 50% figure after another 6 months. The failure rate for drug use however, continues to remain low, but the crime rate picks up. In other words, addicts exposed to institutional therapy tend to stay away from drugs, but continue to commit criminal acts. Criminal activity appears to be of a minor nature (usually against property) in the form of larcenies.

Several addicts, exposed to institutional therapy, were arrested several times for stealing cartons of cigarettes from food markets. Several were returned for non-support charges. Some were arrested for selling or possessing marihuana but not heroin. Selling marihuana for extra cash for Christmas spending money contributed to the failure rate.

Of those addicts who had institutional therapy that returned to heroin use, most turned themselves in for short reincarceration. This action is rarely found among addicts who did not have institutional therapy.

Some addicts are lost immediately upon their release because they fear bodily harm from persons in the community against whom they once testified or gave information about to the police. There is very little control over this, and only after the addict absconds do we find the reason for his errant behavior.

In the main, the institutional therapy program has been encouraging. Three persons have completed nine-month barbering courses taken with the help of the State's rehabilitation program, have received their apprentice licenses and are employed as barbers. Several others are involved in other school courses. Some of the addicts now off parole continue to come to the therapy sessions and seem interested in taking a therapist role with addicts new to the program. Most of these addicts are regularly employed and saving money. By and large, the prognosis for addicts who have had institutional therapy is much better for long term results than addicts not exposed to this part of the program. Even if these addicts must be returned several times after making some false starts, the cumulative effects of extensive exposure to therapy begin to have a positive influence.

Some interesting behaviors occur with this population. When excellent rapport is established and an addict fails and is returned to the institution, he sometimes becomes too embarrassed to return to the institutional group. When re-released they appear to make a valiant effort to go straight to prove they are not failures.

It is relatively easy to determine who will return to their former dysocial life when released from institutional therapy. In most cases their behavior changes from heightened group interaction while institutionalized to passive withdrawal in the community group. Weight loss is easily discernible with these addicts because the same therapist has seen them for a long time and can readily spot physiological changes as they occur.

There appears to be little if anthing negative concerning the institutional therapy program conducted by the Pennsylvania Board of Probation and Parole, and those involved in it are convinced it has added an essential dimension to the eventual readjustment of the addict to fruitful community functioning.

It is recommended that the program continue and be enlarged.

COMMENTARY

The Philadelphia Narcotic Project is one of the few successful programs dealing with addiction in the United States. Originally, the purpose of the unit was to attempt to study the addiction problem in Philadelphia to determine what rates of failure and success could be expected for addicts on parole, and what methods could be instituted from other programs currently in vogue or what new methods could be devised to reduce these failure rates of addicts to the same level of other parolees who were not addicted. At the time the unit first began to function, most of the treatment philosophy came out of California, the New York City area, and the Federal govenment. Their treatment philosophy basically was to give chemical (drug) or analytic type therapy to addicts. Both these treatment philosophies have been unsuccessful, and the problem of addiction in California and New York increased. The current ideas now are still nurturance and support of addicts through wider and wider community involvement into the problem. The Philadelphia Narcotic Program took an opposite philosophic treatment approach. It was determined here that addicts were basically irrationally, dependent individuals who would have to function more independently of drugs and other external sources if they ever hoped to mature out of their addictive life. Consequently, support and nurturance was minimized and emphasis was placed on making them function on their own, learning by their mistakes, while steps were taken to reduce their irrationalities and improve their judgment. It was found that addicts attempt to avoid reality situations for self improvement,

and hence, mandatory features under close supervision were instituted. Basically, addicts were placed into a learning maze situation and allowed to make their own choices within the maze, being responsible themselves for the judgments they made. Essentially, the Narcotic Unit functioned as the dependent variable acting only after the addict first made his own choice. In this way, the addict was made the independent variable.

In the treatment maze, addicts had a choice of attending therapy, not using drugs, working and saving money; or violating their parole. If they violated their parole they were placing themselves in jeopardy of returning to treatment within an institutional setting. Returning to an institution was their irrational alternative which they could make. Eventually, many addicts realized their poor judgments and began to think and function adequately. Addictive drugs of any kind, narcotic or not, were disallowed, including alcohol intake. The Narcotic Unit found that addicts did not need supportive drugs unless they had severely painful medical problems that orindarily would call for analygesic therapy. The Narcotic Unit also found strikingly different personality types who used drugs for various psychological reasons, and who responded to different therapy methods with varying degrees of success. None, however, responded to nurturance, psychological, or analygesic support with success. The Narcotic Unit also found that treatment methods employed with other populations (neurotic, psychotic, etc.) did not meet with success. In fact, the Narcotic Unit found addicts responding to a rational, directive, occasionally didatic behavioral conditioning therapy approach. It was found that addicts were extremely naive about the basic facts of life, and had

very limited coping mechanisms to deal with the mundane, ordinary social and economic problems of living. At every opportunity, dependence upon family and/or other controlling forces was discouraged and irrational ideas and feelings about them desensitized. The results were encouraging and rewarding. It was found that many addicts could be successfully treated by our methods. In the long run, the directive type of treatment philosophy was the method of choice by many of the addicts themselves who had been exposed to other treatment methods. As with other populations in therapy, addicts who were more intelligent, less primitive, and more socially motivated, responded best to treatment, obtained the most benefit from it, employed what they learned more successfully and succeeded at the highest rate. On the other hand, the very primitive addicts with severe assaultive tendencies and almost unshakable criminally paranoid ideation never succeeded with our treatment methods for very long, and is currently believed by this writer that these primitive types should be maintained on long-term methadone treatment therapy. Although there are very few addicts of this ilk, they have a pronounced sick influence upon the weaker addict types, constantly interfering with therapeutic influences and frequently enlisting the aid of weaker addicts to carry out dangerous crimes against the community. Because of the experimental nature of the Narcotic Project, this primitive type was treated routinely if they randomly fell into Group III. However, it is believed that had they been eliminated from treatment groups, the success rates might have been improved. Their personality type can be described as inadequate personalities with assaultive criminal features, strong paranoid-schizaphrenic-like thought processes

and impulsive verbal agressiveness. Invariably, they never work, are supported by their mothers upon whom they are patriotically attached, and have long criminal records including several long term incarcerations for crimes against persons. They never marry or become involved with long term relationships with other women. This type of primitive addict became surly and assaultive if placed under the normal pressures of the treatment maze, and because of his instability he was supervised with some trepidation both by the therapist and parole agent. His paranoia literally preempted therapeutic efforts to attempt to change him.

Young addicts in their late teens or early twenties tend to return to drug abuse at a more rapid rate, and definitely need at least one year to two years of institutional therapy before one can successfully work with them in the community--especially if they are sophisticated users of heroin. L.S.D., marihuana, or amphetamine users of short duration can be successfully dealt with in the community under close parole supervision. In all cases addicts must be made to find and sustain employment. Any addict who wants to work can readily find employment in the community. The only addicts who cannot find work are looking for employment from their rooftops. Moreover, school and training schools are open to them. They qualify for State rehabilitation programs simply because they are addicted. It is distressing to see persons in high office taken in by addicts who tell them no one will hire them because of their record or addictive affliction. Let it be known that approximately 90% or more of the several hundred addicts in the Philadelphia Narcotic Unit are employed at any one time, simply because we insist upon it. Many addicts will tell the group during therapy

of numerous available jobs. Only those who do not wish to work cannot find it.

Another myth which should be exploded concerns the apparent decline of the use of narcotic drugs after the age of 35. The average age of the addicts in the Philadelphia Narcotic Unit is 35. It is quite apparent that reports by professionals who are supposedly expert in the field have inundated the literature with their own naivety and limited experience, especially in areas of clinical findings. Narcotic addiction is an extremely complicated problem. To properly understand it one must be familiar with the entire scope of the mental health field including recent findings in physiology, endocrinology, chemistry and psychology. One finds more misinformation than truth about addiction in the clinical literature, and a general rule to use when reading about narcotics might be to believe the opposite of what is written. Clinicians persist in using methods which obviously do not work and they never seem to change even in the face of repeated failure. One sometimes wonders if the main problem in addiction isn't the therapist rather than the addict. Good intentions and poor methods rarely are a successful combination, and never cure addiction. Professionals in this area will have to shake off those methods that do not work and experiment with new ideas currently available and enlarge or amend them with ingenuity to be more successful. Because professionals have not taken the lead, a vacuum was created that is presently being filled by laymen. In the field of addiction everyone is an expert. Clergymen, judges, social workers, sociologists, educators, administrators, and many others who have known some addicts or read a magazine article

have developed definitive, hardened opinions of how to treat addicts. This hampers new creative approaches when they are suggested.

An Ethical Syndrome has developed about the area of treatment of addicts which sounds similar to the concept propounded for alcoholics. Alcoholics are considered "sick" individuals, not criminals. Consequently, the necessary control of alcoholics needed for their cure has been eliminated. They are outside the law and consequently have become a thorn in the side of the mental health field. Attempts at voluntary treatment have been unsuccessful at curing alcoholism. This same unsuccessful philosophy that addicts--like alcoholics--are "sick" and should not be treated as criminals, ergo, remove the legal control over them, is making inroads. In the forefront of this movement are persons concerned with civil rights of citizens and other defenders of the downtrodden and the oppressed.

From this clinician's point of view, this philosophy will be noncurative if it becomes operative. Like the alcoholic, who needs external control initially to properly manage his life, and make him finally self operative and independent, the addict will be civilly righted and uncured. It is believed this victory if it should occur, will be a petty and hollow one for the law and a terrible victory for the addict as it presently is for the alcoholic.

Professionals, with a misguided notion that they should not "play God" (one of their favorite expressions), are simply passing up their authority and schooled judgment to others who are less adequately equipped to cope with the problems of treatment. In effect, these professionals are saying,

the ends do not justify the means. (This writer believes that when the ends are benevolent for both the individual and society, the means are justified.)

Those professionals who are against authoritarian methods to effect cures are operating under archaic methods for impulsive, additive disorders. Addicts are not in control of their own lives, but are controlled by malevolent, external elements--addictive drugs--and by malevolent individuals who traffic in these drugs. The end result of the benevolent professional not taking charge for society is to desert the addict to a dysocial, non-fruitful, non-productive life without the addict being able to make this choice for himself.

Significantly, as Tolstoy predicted in his book "War and Peace," those least involved in the action (treatment) propound these ideas of no control. Suddenly, it is less important to cure than it is to allow them the freedom to socially, morally, and mentally deteriorate.

It would seem that professionals, fearful of the addicts' civil rights, are transgressing their area of involvement-treatment, and have entered the field of jurisprudence; and legal experts who have set themselves up as the judges of how addicts should be treated, have transgressed their area of involvement. The addict, with his theatrical cries of "I'm sick," "I need drugs," or "I'm not a criminal, I just can't control myself," are again successfully manipulating, in their psychopathic manner, the naive and uninformed to leave them free to remain addicted.